		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020206

Facility Name: Greenwood Manor Nursing Home

Address: 410 Fletcher (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: 618 498 6427 **Fax #** 618 498 3339

IDPA ID Number: 6003842

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Barbara Molloy **Telephone Number:** 618 498-6427

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Barbara Molloy
(Title) Assistant Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Dennis E. Ulrich, Certified Public Accountant
(Firm Name & Address) Scheffel & Company, P.C.
143 North Kansas, Edwardsville, IL 62025
(Telephone) (618) 656-1206 Fax # (618) 656-3536

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16			16	8
9	SNF/PED					9
10	ICF	21,391	4,856		26,247	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,407	4,856		26,263	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.42%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/28/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	113,480	18,830	6,523	138,833		138,833		138,833			1
2	Food Purchase		130,405		130,405		130,405		130,405			2
3	Housekeeping	51,153	15,319		66,472		66,472		66,472			3
4	Laundry	60,490	20,113		80,603		80,603		80,603			4
5	Heat and Other Utilities			85,193	85,193		85,193		85,193			5
6	Maintenance	54,211		48,994	103,205		103,205		103,205			6
7	Other (specify):*											7
8	**TOTAL General Services**	279,334	184,667	140,710	604,711		604,711		604,711			8
	B. Health Care and Programs											
9	Medical Director			12,100	12,100		12,100		12,100			9
10	Nursing and Medical Records	699,361	63,897	10,693	773,951		773,951		773,951			10
10a	Therapy			12,422	12,422		12,422		12,422			10a
11	Activities	34,697	5,652		40,349		40,349		40,349			11
12	Social Services	20,247			20,247		20,247		20,247			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Books purchased**			50	50		50		50			15
16	**TOTAL Health Care and Programs**	754,305	69,549	35,265	859,119		859,119		859,119			16
	C. General Administration											
17	Administrative	59,400		9,915	69,315		69,315	(9,915)	59,400			17
18	Directors Fees											18
19	Professional Services			56,509	56,509		56,509	967	57,476			19
20	Dues, Fees, Subscriptions & Promotions			30,906	30,906		30,906	(21,431)	9,475			20
21	Clerical & General Office Expenses	44,278	7,274	37,331	88,883		88,883	(1,100)	87,783			21
22	Employee Benefits & Payroll Taxes			206,320	206,320		206,320		206,320			22
23	Inservice Training & Education											23
24	Travel and Seminar			966	966		966		966			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,506	32,506		32,506		32,506			26
27	Other (specify):*											27
28	**TOTAL General Administration**	103,678	7,274	374,453	485,405		485,405	(31,479)	453,926			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,137,317	261,490	550,428	1,949,235		1,949,235	(31,479)	1,917,756			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Greenwood Manor Nursing Home #0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,931	13,931		13,931	41,670	55,601			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,172	12,172		12,172	(12,172)				32
33	Real Estate Taxes							25,880	25,880			33
34	Rent-Facility & Grounds			156,000	156,000		156,000	(156,000)				34
35	Rent-Equipment & Vehicles			4,702	4,702		4,702		4,702			35
36	Other (specify):*											36
37	**TOTAL Ownership**			186,805	186,805		186,805	(100,622)	86,183			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			53,802	53,802		53,802		53,802			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,137,317	261,490	791,035	2,189,842		2,189,842	(132,101)	2,057,741			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,904	30		9
10	Interest and Other Investment Income	(12,172)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,545)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,370)	17		18
19	Entertainment				19
20	Contributions	(1,145)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,781)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(19,180)	20		28
29	Other-Attach Schedule PAC Dues	(470)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,759)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(108,342)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (108,342)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (132,101)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Greenwood Manor Nursing Home

ID# 0020206

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Dues	$ (470)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
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54				54
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56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(470)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(9,915)	0	0	0	0	0	0	0	0	0	0	(9,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	967	0	0	0	0	0	0	0	0	0	967	19
20	Fees, Subscriptions & Promotions	(21,431)	0	0	0	0	0	0	0	0	0	0	(21,431)	20
21	Clerical & General Office Expenses	(1,145)	45	0	0	0	0	0	0	0	0	0	(1,100)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(32,491)	1,012	0	0	0	0	0	0	0	0	0	(31,479)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,491)	1,012	0	0	0	0	0	0	0	0	0	(31,479)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Greenwood Manor Nursing Home **#** 0020206 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	20,904	20,766	0	0	0	0	0	0	0	0	0	41,670	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,172)	0	0	0	0	0	0	0	0	0	0	(12,172)	32
33	Real Estate Taxes	0	25,880	0	0	0	0	0	0	0	0	0	25,880	33
34	Rent-Facility & Grounds	0	(156,000)	0	0	0	0	0	0	0	0	0	(156,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,732	(109,354)	0	0	0	0	0	0	0	0	0	(100,622)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,759)	(108,342)	0	0	0	0	0	0	0	0	0	(132,101)	45

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Lawrence B. Plummer	100.0%	Greenwood Manor, West, Inc.	Jerseyville	Greenwood Manor Land Trust	Jerseyville	Rental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional	$	Greenwood Manor Land Trust	66.67%	$ 967	$ 967	1
2	V	30	Depreciation		Greenwood Manor Land Trust	66.67%	20,766	20,766	2
3	V	33	Real Estate Taxes		Greenwood Manor Land Trust	66.67%	25,880	25,880	3
4	V	34	Rent	156,000	Greenwood Manor Land Trust	66.67%		(156,000)	4
5	V	21	General Admin.		Greenwood Manor Land Trust	66.67%	45	45	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 156,000			$ 47,658	$ * (108,342)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Barbara Molloy	Asst. Administrator	Administration	0.00%	30,000	40	100.00	Wages	$ 14,700	17-1	1
2	Lawrence B. Plummer	Medical Director	Medical Director	100.00%	2,050	8	100.00	Fees	12,100	9-3	2
3	Sue Plummer	Administrator	Administration	0.00%	0	40	100.00	Wages	44,700	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 71,500		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	State Bank Of Jerseyville		X	Operating Loan			160,000	160,000	11/16/01	PRIME + 1	12,172	6
7												7
8	Less: Interest Income Offset										(12,172)	8
9	TOTAL Facility Related						$ 160,000	$ 160,000			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 160,000	$ 160,000			$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	26,115	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	25,880	2
3. Under or (over) accrual (line 2 minus line 1).	$	(235)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,115	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	25,880	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	26,307	8
	1996	26,556	9
	1997	25,861	10
	1998	25,861	11
	1999	25,880	12

Line 2 is 1999 taxes paid in 2000.

Line 4 is equal to taxes paid for 1999 in 2000.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,627 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	To accommodate Bldg		1973	$ 15,000	1
2	and Parking	153,475	1981	1,267	2
3	TOTALS	153,475		$ 16,267	3

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1974	1974	$ 775,750	$ 19,394	40	$ 19,394	$	$ 523,631	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer			1974	28,540		10			28,540	9
10	Air Conditioner			1980	8,000		8			8,000	10
11	Air Conditioner			1981	8,000		5			8,000	11
12	Air Conditioner			1982	1,387		5			1,387	12
13	Air Conditioner			1983	2,323		5			2,323	13
14	Wiring			1983	1,760		7			1,760	14
15	Additional Parking			1984	2,050		15			2,050	15
16	Air Conditioner			1984	1,241		5			1,241	16
17	Painting/Wallpaper			1981	3,520		8			3,520	17
18	Ice Machine			1981	1,308		5			1,308	18
19	Building Repair			1981	1,560		5			1,560	19
20	Redecorating Rooms			1981	14,804		7			14,804	20
21	Lighting			1986	3,206	169	20	160	(9)	2,431	21
22	Air Conditioner			1986	1,329		8			1,329	22
23	Air Conditioner			1986	3,775		8			3,775	23
24	New Walls			1986	1,318	69	20	66	(3)	945	24
25	Roof			1987	29,000	921	30	967	46	12,567	25
26	Cabinets			1988	1,045		20	52	52	645	26
27	Water Heater			1988	3,375		15	225	225	2,757	27
28	Smoke Alarms			1988	8,144		20	407	407	4,909	28
29	Water Softner			1989	6,225		15	415	415	4,565	29
30	Handicap Drinking Fountain			1990	1,794		15	120	120	1,266	30
31	Compressor for Air Conditioner			1990	1,194		8			1,194	31
32	Privacy Curtains & Tracks			1991	3,675		10	367	367	3,645	32
33	Water Heater			1992	4,039		15	269	269	2,401	33
34	Landscaping			1992	1,500	89	10	150	61	1,325	34
35	Carpeting			1995	16,083		10	1,608	1,608	8,175	35
36	TOTAL (lines 4 thru 35)				$ 935,945	$ 20,642		$ 24,200	$ 3,558	$ 650,053	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing			1996	1,400	125	15	93	(32)	427	9
10	Roof			1988	30,138	957	30	1,005	48	12,307	10
11	Building Improvements			1989	19,293	612	30	643	31	7,288	11
12	Window Covering			1990	1,558		10	91	91	1,558	12
13	Air Conditioners			1989	2,557		8			2,557	13
14	Light Posts & Lights			1990	1,080		15	72	72	768	14
15	New Ductwork			1990	2,983	95	20	149	54	1,566	15
16	Rubrails & Wall Guards			1990	5,038		10	125	125	5,038	16
17	Curtains & Tracks			1990	2,859		10	286	286	2,859	17
18	Building Improvement			1990	47,877		30	1,596	1,596	16,757	18
19	Hand Rails			1990	3,409		10	170	170	3,409	19
20	Cubicle Curtains			1991	2,150		10	215	215	1,989	20
21	Privacy Curtains/Tracks			1991	8,576		10	858	858	8,433	21
22	Kitchen Floor			1991	2,820		10	282	282	2,655	22
23	Privacy Curtains/Tracks			1991	5,763		10	576	576	5,522	23
24	Room Air Conditioner			1991	1,403		8			1,403	24
25	Hand Rails			1991	5,944		10	594	594	5,894	25
26	Building Improvement			1991	5,358		15	357	357	3,393	26
27	Landscaping			1992	2,691	159	10	269	110	2,332	27
28	Air Conditioner-Roof top			1992	26,075	828	20	1,304	476	10,865	28
29	Wallpaper & Cove			1992	1,768		10	177	177	1,444	29
30	Sprinkler System			1993	1,399	44	25	56	12	438	30
31	Ceiling Fan			1993	349	15	15	23	8	166	31
32	Windows			1993	3,750	119	15	250	131	1,771	32
33	Windows			1994	7,050	181	30	181		1,258	33
34	Windows			1994	5,800	149	30	149		1,010	34
35	Windows			1994	216	6	30	6		37	35
36	TOTAL (lines 4 thru 35)				$ 199,304	$ 3,290		$ 9,527	$ 6,237	$ 103,144	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Air Conditioner			1994	1,574		8	197	197	1,246	9
10	Call Lights			1994	3,132		15	209	209	1,323	10
11	Door Control System			1994	891		15	59	59	366	11
12	Call Light System			1995	6,607	578	15	441	(137)	2,644	12
13	Door Alarm System			1995	2,252	197	15	150	(47)	901	13
14	Call Lights			1995	791	69	15	53	(16)	308	14
15	Windows			1996	12,187	312	30	406	94	1,862	15
16	Nurses Station			1996	6,760	173	20	338	165	1,437	16
17	Remodelling			1997	3,360	86	39	86		337	17
18	Shower Room			1998	19,285	494	40	482	(12)	1,125	18
19	Roof			1998	10,000	256	40	250	(6)	583	19
20	Roof			1999	75,469	1,935	40	1,887	(48)	3,774	20
21	Remodeling- Kitchen walls, floor			2000	6,500	34	40	41	7	41	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 148,808	$ 4,134		$ 4,599	$ 465	$ 15,947	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 198,557	$ 3,750	$ 16,792	$ 13,042	12	$ 114,215	37
38	Current Year Purchases	5,328	933	483	(450)	10	483	38
39	Fully Depreciated Assets	289,797				10	289,797	39
40								40
41	TOTALS	$ 493,682	$ 4,683	$ 17,275	$ 12,592		$ 404,495	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Care	1996 Auto	1995	$ 24,000	$ 1,775	$	$ (1,775)	4	$ 24,000	42
43	Patient Care	1996 Auto Sales Tax	1996	1,500	173		(173)	4	1,500	43
44										44
45										45
46	TOTALS			$ 25,500	$ 1,948	$	$ (1,948)		$ 25,500	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,819,506	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 34,697	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 55,601	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 20,904	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,199,139	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 4,702 Description: postage meter, $1,054; public storage space, $3,648
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,869	$ 19,833	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	326,474	326,474	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,538	31,538	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	524,016	488,345	8
9	Other(specify): Prepaid Income Taxes	17,082	17,082	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 917,979	$ 883,272	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	539,974	539,974	12
13	Land		16,267	13
14	Buildings, at Historical Cost		856,608	14
15	Leasehold Improvements, at Historical Cost	290,068	323,558	15
16	Equipment, at Historical Cost	532,099	558,154	16
17	Accumulated Depreciation (book methods)	(594,724)	(1,239,572)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 767,417	$ 1,054,989	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,685,396	$ 1,938,261	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 171,805	$ 171,805	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	160,000	160,000	29
30	Accrued Salaries Payable	46,063	46,063	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,526	1,526	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Income Tax	57,104	57,104	36
37		0		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 436,498	$ 436,498	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 436,498	$ 436,498	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,248,898	$ 1,501,763	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,685,396	$ 1,938,261	48

***(See instructions.)**

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,260,951	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,260,951	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,053)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (12,053)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,248,898	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,091,692	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,091,692	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,168	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,168	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,553	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,553	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Investment Income	36,078	28
28a	Reimbursement for use of auto	6,750	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 42,828	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,170,241	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	604,711	31
32	Health Care	859,119	32
33	General Administration	485,405	33
	B. Capital Expense		
34	Ownership	186,805	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	53,802	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,189,842	40
41	**Income before Income Taxes (line 30 minus line 40)****	(19,601)	41
42	**Income Taxes**	7,548	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (12,053)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No, cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 37,959	$ 18.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,144	5,174	79,279	15.32	3
4	Licensed Practical Nurses	9,802	10,324	118,334	11.46	4
5	Nurse Aides & Orderlies	54,119	57,548	426,947	7.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,727	4,188	36,842	8.80	8
9	Activity Director	1,795	2,022	17,593	8.70	9
10	Activity Assistants	1,808	2,010	17,104	8.51	10
11	Social Service Workers	1,960	2,080	20,247	9.73	11
12	Dietician					12
13	Food Service Supervisor	2,470	2,645	25,962	9.82	13
14	Head Cook	3,293	3,338	23,366	7.00	14
15	Cook Helpers/Assistants	6,369	6,636	44,768	6.75	15
16	Dishwashers	3,171	3,171	19,384	6.11	16
17	Maintenance Workers	4,800	4,915	54,211	11.03	17
18	Housekeepers	6,631	7,193	51,153	7.11	18
19	Laundry	8,462	8,854	60,490	6.83	19
20	Administrator	1,840	2,080	44,700	21.49	20
21	Assistant Administrator	1,840	2,080	14,700	7.07	21
22	Other Administrative					22
23	Office Manager	1,840	2,080	23,467	11.28	23
24	Clerical	1,920	2,080	20,811	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,951	130,498	$ 1,137,317 *	$ 8.72	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	128	$ 6,523	1-3	35
36	Medical Director		12,100	9-3	36
37	Medical Records Consultant	80	2,676	10a-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	0			39
40	Physical Therapy Consultant	144	4,250	10a-3	40
41	Occupational Therapy Consultant	0			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	43	1,900	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	86	3,596	10a-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	481	$ 31,045		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	701	10,693	10-3	52
53	TOTAL (lines 50 - 52)	701	$ 10,693		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Plummer	Administrator	0.00%	$ 44,700
Barbara Molloy	Asst. Administrator	0.00%	14,700
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,400

B. Administrative - Other

Description	Amount
Sales Tax	$ 3,545
Civil Penalty	6,370
TOTAL (agree to Schedule V, line 17, col. 3)	$ 9,915
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Scheffel & Company	Accounting	$ 34,794
Stratton, Stone, Kopee & Strum	Legal	15,372
McMahon, Berger Professionals	Legal	977
Other Consulting	Consulting	808
Automated Data Processing	Payroll	5,421
Farrell, Hunter, Hamilton	Legal	104
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 57,476

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,761
Unemployment Compensation Insurance	12,621
FICA Taxes	89,300
Employee Health Insurance	20,070
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	168
Other Employee Benefits	13,400
TOTAL (agree to Schedule V, line 22, col.8)	$ 206,320

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	1,282
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising & Promotional	25,582
Dues & Subscriptions	4,042
Less: PAC dues	(470)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,781)
Yellow page advertising	(19,180)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,475

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	966
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 966

**See instructions.

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Greenwood Manor Nursing Home # 0020206 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Healthcare Assoc. $3,886

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. Disposable only $4,749 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 53,802
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ NONE Has any meal income been offset against related costs? NO Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.